



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

STAR ANESTHESIA PA  
SUITE 900  
45 NORTHEAST LOOP  
SAN ANTONIO TX 78216

#### **Respondent Name**

DALLAS NATIONAL INSURANCE CO

#### **Carrier's Austin Representative**

Box Number 19

#### **MFDR Tracking Number**

M4-11-1353-01

#### **MFDR Date Received**

December 27, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Anesthesia performed by an anesthesiologist for a surgery performed by a separate surgeon cannot be considered included in any other charge. It must be paid separately."

**Amount in Dispute:** \$ 972.33

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Requesting Party is simply mistaken about the State Fee Guideline reimbursement rates. As evidenced by the attached EOBs, the Workers Compensation State Fee Guideline for the initial service is \$0 because it is part of a bundled amount. Thus, the total amount of reimbursement for the \$1,800 billed by the Requesting Party is, according to the State Fee Guidelines, \$0 because it was paid as part of a separate bundled service. Further, the carrier denied the request based on the contractual agreement between the subject parties. Therefore, the carrier request the Division issued a findings that the Requesting Party is due no further reimbursement."

**Response Submitted by:** Lewis & Backhaus, PC

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2010	01630-AA	\$972.33	\$970.70

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45 – Charges exceed your contracted legislated fee arrangement
- 97 – Payment is included in the allowance for another service procedure
- U837 – Anesthesia is included in the surgery procedure
- Z551 – This charge was reviewed reduced according to payer's instructions

### **Issues**

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. The insurance carrier reduced disputed services with reason code "45 – Charges exceed your contracted legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on January 5, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as a documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement.

Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required.

The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment pursuant to the applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor disputes non-payment of CPT code 01630 rendered on April 23, 2010.

A review of the submitted medical bill finds that the requestor appended modifier AA to CPT code 01630. CPT code 01630 is defined as "Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified" and modifier –AA identifies that "Anesthesia services performed personally by anesthesiologist."

The division completed NCCI edits to help identify edit conflicts that would affect reimbursement. The requestor billed the following CPT codes 64415 and 01630 on April 23, 2010. The following was identified:

Per CCI Guidelines, Procedure Code 64415 [SINGLE NERVE BLOCK INJECTION ARM NERVE] has a CCI conflict with Procedure Code 01630 [ANES ARTHRS HUMERAL H/N STRNCLAV & SHOULDER NOS]. Review documentation to determine if a modifier is appropriate. The requestor seeks reimbursement for CPT code 01630 which does not contain NCCI edit conflicts. Therefore the disputed CPT code 01630 will be reviewed pursuant to 28 Texas Administrative Code §134.203.

3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

The Division reviewed the submitted CMS-1500 (bill) and finds that the anesthesia was started at 7:36 and ended at 10:49, for a total time of 193 minutes.

Per CMS one anesthesia time unit = 15 minutes of anesthesia time. The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth. Therefore, the requestor has supported  $193/15 = 12.87$ .

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Anesthesia Base Units for CPT code 01480 is 05; the 2010 DWC Conversion Factor is \$54.32.

The MAR for CPT code 01630-AA is: (Base Unit of 5 + Time Unit of 12.87) X \$54.32 DWC conversion factor = \$970.70. Therefore, this amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$970.70.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$970.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 17, 2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**